Department of Health and Human Services
Health Care Financing Administration
Operational Policy Letter #81
OPL99.081

DATE: February 10, 1999

SUBJECT: Medicare + Choice (M+C) Organizations Appeal and Grievance Data Disclosure Requirements

SUMMARY:

This operational policy letter (OPL) provides guidance on the manner and form in which M+C organizations will be expected to comply with disclosing grievance and appeal data to eligible Medicare individuals upon request. In order for plans to prepare for this new responsibility, the first reporting to beneficiaries will not go into effect until January 1, 2000.

BACKGROUND INFORMATION:

Part 422 of Title 42 of the Code of Federal Regulations (CFR) distinguishes between certain information that an M+C organization must provide to each enrollee, on an annual basis, and information that the M+C organization must disclose to any M+C eligible individual upon request. This requirement can be found in § 1852 (c)(2)(C) of the Social Security Act and part 422 CFR (42 CFR § 422.111(c)(3)). The requirement states that M+C organizations must disclose information pertaining to the number of disputes, and their disposition in the aggregate, with the categories of grievances and appeals to any individual eligible to elect an M+C plan who requests this information.

Data categories are based on the M+C organization's grievance and appeal processes as prescribed under 42 CFR, Subpart M of Part 422. An organization determination, as defined in § 422.566, is an M+C's decision about covering a service or paying for the service that an enrollee can dispute through the appeal process. The appeal process begins when an M+C organization is asked to reconsider an adverse organization determination; it is at this point that an M+C organization must begin to maintain and provide data. For purposes of this OPL, we are requiring M+C organizations to report appeal data up through Health Care Financing Administration's (HCFA) independent review entity level of appeal. In the future, HCFA may require M+C organizations to report data at further levels of appeal, i.e. the administrative law judge (ALJ), Departmental Appeals Board (DAB) review and judicial review.

M+C organizations are required by the statute and the M+C regulation to provide the information discussed in this OPL beginning 1/1/99. However, we will not require that M+C organizations comply with this OPL until 4/1/99 in order to allow M+C organizations a reasonable amount of time to accumulate meaningful data. The 4/1/99 date will apply to all M+C organizations that have converted or are converting to M+C organizations, so that they can accumulate data on complaints that arise once they have M+C organization status. M+C

organizations will be required to report data to beneficiaries beginning 1/1/2000 (see Data Collection and
Reporting Periods).

There has been considerable interest from the public in obtaining appeal and grievance data from managed care organizations. In May 1998, the General Accounting Office (GAO) reported in *HMO Complaints and Appeals: Most Key Procedures in Place, but Others Valued by Consumers Largely Absent* that "publicly available data on the number and types of [grievances] and appeals, if defined and collected in a consistent fashion, could enhance oversight, accountability, and market competition. Such information would offer regulators, purchasers, and individual consumers a better opportunity to evaluate the relative performance of health plans. . . . If these data were standardized and publicized, [M+C organizations] could compete on the basis of [grievance] and appeal rates" which would provide consumers with important material needed to compare plans.

In moving forward to determine the data that M+C organizations would report to beneficiaries, HCFA needed to understand the operational implications of implementing the requirement in 42 CFR § 422.111(c). HCFA set out to understand the types of measures that M+C organizations reasonably could be expected to collect based upon current operations and the extent to which these data would be helpful to prospective enrollees. In the Fall of 1998, HCFA formed an Appeal/Grievance/Complaint Workgroup to accomplish these goals. The workgroup was comprised of representatives from consumer advocacy groups, managed care plans, Peer Review Organizations, HCFA's independent review entity and HCFA's central and regional offices. The following requirements are based on that consultation.

APPEALS:

When an enrollee requests coverage for a particular service, the decision on whether to provide such coverage is considered an organization determination. Section 422.578 et. seq. provides that an enrollee has a right to request either a standard or expedited reconsideration whenever an M+C organization has denied an enrollee's request for coverage. Where the M+C organization affirms its adverse organization determination, in whole or in part, the M+C organization must automatically forward the case file to HCFA's independent review entity so that it may make a final reconsidered determination. [HCFA contracts with the Center for Health Dispute Resolution (CHDR) to provide this function.]

GRIEVANCES:

The regulations at 42 CFR §422.564 require that M+C organizations provide meaningful procedures for the timely hearing and resolving of enrollees' grievances. Section 422.561 of 42 CFR defines a grievance as any complaint or dispute other than one involving an organization determination as defined in § 422.566(b). This year, HCFA plans to publish a Notice of Proposed Rulemaking (NPRM) which will establish a standard grievance process.

APPEAL AND GRIEVANCE DATA COLLECTION AND REPORTING REQUIREMENTS:

The attached document includes the measures that you are expected to collect. These line by line instructions should be used as a format to record your appeal and grievance data. It is also the format that HCFA expects M+C organizations to follow in reporting the data to beneficiaries.

Please note that M+C organizations should limit their reporting of grievances only to those which involve quality of care complaints. HCFA will wait until it has established a standard grievance procedure prior to requiring M+C organizations to report other categories of grievances. Since most states already regulate quality of care issues, HCFA expects that reporting in this area should not pose a problem for M+C organizations. General reporting requirements are discussed in more detail later in this OPL.

Beneficiaries who request data must receive both appeal and grievance data that you are being asked to record in its totality. M+C organizations should not send out a subset or partial list of the data, even if only a subset of the data is requested. For example, if a beneficiary requests data on the number of appeals received by the M+C organization, then the M+C organization would send the beneficiary a complete report of both its appeal and grievance data for the reporting period.

Note that Line 4 of the appeal data collection, and Line 4 of the grievance data collection requirements ask for the number of appeal and grievance requests per 1000 enrollees. The purpose of this calculation is to normalize reporting among larger and smaller M+C organizations for comparison purposes. Since larger organizations would reasonably be expected to receive more appeals and grievances relative to smaller organizations, simply reporting raw data could be misleading.

The rate is calculated by multiplying the total number of requests for [an appeal or grievance] by 1,000, and dividing that number by the average number of members enrolled during the data collection period. It does not require that the M+C organization have a minimal enrollment of 1000 members.

The following are examples of how the rates get normalized across small and large plans:

Example 1

M+C organization average membership = 500
# of appeals received during the data collection period = 4
4 x 1000/500 = 8
# of Appeals per 1000 members = 8

Example 2

M+C organization average membership = 5000
# of appeals received during the data collection period = 40
40 x 1000/5000 = 8
# of Appeals per 1000 members = 8

Reporting Unit for Appeal and Grievance Data Collection Requirements

The reporting unit for appeal and grievance data is to be consistent with the reporting unit for the Health Plan Employer Data and Information Set (HEDIS), the Medicare Consumer Assessment of Health Plans Study (CAHPS), and the Medicare Health Outcomes Survey (HOS) which is the "contract market." These instructions can be found in OPL99.078.

As described in OPL 99.078, there, the contract market implies either reporting by contract or by a market area within a contract. M+C organizations must report for each contract unless HCFA divides the contract service area into "market areas." When the contract service area is subdivided, the resulting market areas cover more than one major community or city and each market area has at least 5,000 Medicare enrollees. In these situations, M+C organizations will report two or more sets of data for a given contract. This approach will provide more meaningful information to beneficiaries. There are no exceptions to reporting by contract market, i.e. you must report by contract or by market area where applicable.

HCFA will assess all contract service areas to determine whether the M+C organization must report by market area. HCFA will notify plans as soon as possible whether they must report by market area and will identify the geography of each market area. M+C organizations that are not notified of market area reporting will report by contract. Since the reporting unit for appeal and grievance data is to be the same as for HEDIS, CAHPS and HOS, M+C organizations must make changes to the reporting unit for appeals and grievances concurrently.

DATA COLLECTION and REPORTING PERIODS:

M+C organizations will be expected to collect and maintain appeal and grievance data beginning 4/1/99. Managed care organizations that have converted or will be converting to M+C organizations will not be expected to report retrospective data. In order for M+C organizations to report data consistently, we have established 1) data collection periods and 2) reporting periods.

- The data collection period is the time frame in which the data were collected. Data collection periods will be based on an ongoing twelve month period. By ongoing, we mean that the prior six months of data are added to the next six months of data in order to come up with a twelve-month data collection period.

- The reporting period refers to the time frame during which organizations will be expected to report the data. The reporting period begins three months after the data collection period ends. Reporting periods are six months in duration.

- Organizations are expected to report out appeal and grievance data to

beneficiaries, upon request, beginning three months after the end of each data collection period. For example, if the data collection period ends 9/30/99, the organization will begin reporting data to the beneficiary 1/1/2000. The three month lag between the end of the data collection period and the beginning of the report period allows the M+C organization to resolve appeals received during the data collection period and ensure quality control over the data reported. Below, we have provided further discussion in order to clarify these concepts.

Initial Data Collection Period: By 4/1/99 and ending 9/30/99, this initial data collection period will include all appeal and grievance data collected by the organization, through final disposition, for the six-month period.

Initial Reporting Period: By 1/1/2000, three months after the initial data collection period ends, M+C organizations will be expected to begin reporting appeal and grievance data through final disposition, for the period from 4/1/99 through 9/30/99. The initial reporting period will last six months, or through 6/30/2000. This is the last date the organization will report on appeal and grievance data collected between 4/1/99 and 9/30/99.

Ongoing Data Collection Periods: The first ongoing data collection period will begin 4/1/99 through 3/31/2000 which includes two six-month data collection periods.

New Reporting Periods Start Every Six Months: M+C organizations will be expected to report out new data every six months. The new data that get reported will include the two most recent data collection periods. For example, following the initial reporting period that runs from 1/1/2000 to 6/30/2000, a new reporting period begins on 7/1/2000 and runs through 12/31/2000. This report will include appeal and grievance data collected beginning 4/1/99 through 3/31/2000 (or the two latest six month data collection periods). Beneficiary requests for appeal and grievance data beginning 1/1/2001 through 6/30/2001 will be based on appeals received by the organization from 10/1/99 through 9/30/2000, and so on.

MAINTAINING DATA:

HCFA expects M+C organizations to maintain a health information system that collects, analyzes and integrates the data necessary to implement these disclosure requirements. M+C organizations will be monitored to ensure that they have a reliable system to maintain and report accurate data. (See Appeal and Grievance Reporting System.)

APPEAL AND GRIEVANCE REPORTS TO BENEFICIARIES:

Part 422 of Title 42 of the CFR requires the Secretary of Health and Human Services to describe "the manner and form" in which the M+C organization must provide the information to the individual requesting it. The attachment to this OPL illustrates the reporting format that should be used in your report to beneficiaries.

M+C organizations should report information regarding appeal and (quality of care) grievance data in the format prescribed by HCFA upon the request of a beneficiary who is eligible to enroll in an M+C plan offered by an M+C organization. In a future OPL, HCFA will develop general guidance and instruction to accompany this chart. This instruction will include guidance on what the data mean or does not mean about the M+C organization's performance in the appeal and grievance area. The guidance that will accompany the data will be provided by HCFA to the M+C organizations prior to the release of the data to the beneficiary community.

In developing its guidance, HCFA plans to confer with representatives from M+C organizations, consumer advocacy groups and communication specialists. Through this process and other means, prior to January 2000, HCFA will alert Medicare beneficiaries, our partners in the National Medicare Education Program (NMEP) and beneficiary advocacy groups of your ability to produce this information.

Reports should be readable and understandable to the recipient of the information. The material also should be typed in at least a 12 point font. Beneficiaries who request M+C organization appeal or grievance data should receive all the appeal and grievance data that you are being asked to record in its totality. M+C organizations should not send out a subset or partial list of the data, even if only a subset of the data is requested. If the M+C organization provides any of its own materials or discussion to supplement HCFA's model format, as with all member materials, prior approval by the Regional Office will be required.

FUTURE APPEAL AND GRIEVANCE REPORTING SYSTEM:

In FY 99, HCFA and its contractors will work with M+C organizations and consumer groups to determine additional information needed to develop a national managed care appeal and grievance data collection and reporting system. Data disclosure requirements will be built into this system. The purpose of this system will be to collect data from enrollees' complaints (i.e. appeals and grievances) at both the M+C organization and independent review entity levels so that HCFA can:

- monitor plan performance on essential requirements;
- improve HCFA's ability to more efficiently track case information about complaints across M+C organizations, the independent review entity, and other HCFA contractors, as necessary (e.g. Peer Review Organizations (PROs) and HCFA's Rapid Response System);
- better understand the phenomenon of managed care complaints;
- report out to beneficiaries comparison performance measures as part of Medicare Compare in order to inform beneficiary choice; and
- support M+C organizations in their local information disclosure requirements to beneficiaries.

HCFA recognizes that the realization of these goals will require a multi-year effort. We intend

to build on the extensive amount of requirements work done as part of the redesign of HCFA's managed care systems. A final determination of our information collection requirements will be done as part of a public process.

This OPL therefore serves to notify M+C organizations that beginning in calendar year 1999, HCFA will begin its first step in collecting beneficiary complaint information directly from M+C organizations. We will collect data about the appeal function in order to baseline the phenomenon, determine the direction from which valid performance indicators will be established, and tentatively target reporting out performance on these measures some time during FY 2001.

Contact:
HCFA Regional Office Managed Care Staff

This OPL was prepared by Beneficiary Membership Administration Group, Center for Beneficiary Services

Attachment

[M+C Organization Name] Appeal and Grievance Data Report

Appeal Data

Line 1. Time Period Covered: [Initial Reporting Period 04/01/99 through 09/30/99].

Line 2. Total Number of Requests for an Appeal Received by [Organization Name]: [insert # here].

Instructions: this line includes all requests for reconsideration, including Pre-Service {standard & expedited} and Claims (Payment) Appeals.

Line 3. Average Number of Enrollees in [Organization Name]: [insert # here].

Instructions: to calculate the number of enrollees, count the number of enrollees at the end of each month of the data collection period. Divide that total by the total number of months in the data collection period.

Line 4. Total Number of Appeal Requests per 1,000 enrollees: [insert # here]

Instructions: this number is calculated by multiplying the total number of requests for an appeal (line #2) by (1,000) and dividing by the total number of enrollees as of the last date of the data collection period (line #3).

Line 5. Of the Appeal Requests Received by [Organization Name] between [04/01/99 through 09/30/99], [Organization Name] completed [insert # here].

Instructions: this number should be equal to or less than the number in line # 2. Organizations are reporting cases received in the period indicated in line # 1, but completed at the M+C organization level within 60 days following the last date in line #1. For example, a withdrawal would be reflected in line #2 as a case received; but since a decision is not rendered for a withdrawn case, a withdrawal would not be reflected in this line item. A "completed" appeal means one that has been resolved by the M+C organization or has left the M+C organization level. We anticipate that the number of completed appeals will be the same as the number of requests for reconsideration, provided the M+C organization has met its deadlines. *Therefore, the organization is accounting for all appeals that it has completed within 60 days after the last date in line # 1.*

The 60-day time frame is based on the maximum time frame in § 422.590(b), which allows an M+C organization 60 days to resolve a dispute involving a claim or payment either by deciding an enrollee should receive payment or by forwarding the case to CHDR. Cases involving requests for services have a shorter

time-frame.

Of those cases:
[Note: partial denials should be recorded as not decided fully in favor of the enrollee.]

Line 6. **[insert # here]** or **[insert % here]** of the appeals were decided fully in favor of the enrollee.

Line 7. **[insert # here]** or **[insert % here]** of the appeals were not decided fully in favor of the enrollee.

Line 8. **[insert # here]** or **[insert % here]** were withdrawn by the enrollee.

[Note: when the decision is not fully in favor of the enrollee, or when the decision is not completed within the required time, as specified in 42 CFR §422.590, the case is automatically sent to the independent review entity (CHDR).]

Line 9. For all appeals received by **[Organization Name]** between **[04/01/99** through **9/30/99]**, **[insert # here]** cases were sent to CHDR for review.

Instructions: *this number should be the same as the number in line #7, provided that all case files were forwarded to CHDR timely.*

Of those cases:

[Note: Partial denials should be recorded as not decided fully in favor of the beneficiary.]

Line 10. **[insert # here]** or **[insert % here]** of **[Organization's Name]** cases reviewed by CHDR were decided fully in favor of the enrollee.

Line 11. **[insert # here]** or **[insert % here]** of **[Organization's Name]** cases reviewed by CHDR were not decided fully in favor of the enrollee.

Line 12. **[insert # here]** or **[insert % here]** were withdrawn by the enrollee.

Line 13. **[insert # here]** or **[insert % here]** are still awaiting a decision by CHDR.

In certain situations, the M+C organization is required to process an appeal faster because delay in making a decision could cause serious harm to the enrollee. This is called an expedited appeal. In many cases, it is the M+C organization that decides whether or not to expedite the appeal.

Instructions: the following measurements are meant to reveal how often the M+C

organization granted requests for the expedited processing of an appeal. Expedited organization determinations are not covered by this measure).

Line 14. Between [04/01/99 through 09/30/99] [Organization Name] received [insert # here] requests for expedited processing for appeals.

Of those cases:

Line 15. [insert # here] or [insert % here] of the requests for expedited processing of the appeal were granted.

Instructions: this line includes cases where the decision was to expedite.

Line 16. [insert # here] or [insert % here] of the requests for expedited processing of the appeal were not granted.

Instructions: *these cases were processed as standard appeals.*

Grievance Data

Line 1. Time Period Covered: **[Initial Reporting Period 04/01/99** through **09/30/99].**

Line 2. Total Number of Grievances Received by **[Organization Name]**: **[insert # here]**.

Instructions: this line should only include grievances that involve quality of care complaints received during the data collection period.

Line 3. Average Number of Enrollees in **[Organization Name]**: **[insert # here]**.

Instructions: to calculate the number of enrollees, count the number of enrollees at the end of each month of the data collection period. Divide that total by the total number of months in the data collection period.

Line 4. Total Number of Grievances received per 1,000 enrollees: **[insert # here]**

Instructions: this number is calculated by multiplying the total number of grievances (line #2) by (1,000) and dividing by the total number of enrollees as of the last date of the reporting period (line #3)).